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Instructions for Completing Initial and Semiannual Management Minutes Questionnaires (MMQs)

General Instructions

- An initial Management Minutes Questionnaire (MMQ) must be submitted for each new MassHealth member at the end of the admission month, or at the end of the conversion month from private or Medicare coverage to MassHealth coverage. An MMQ must also be submitted on a semiannual basis for all MassHealth members who are residents of a nursing facility.
- For new members, codes must reflect the care provided on the effective date forward to the end of the month. For established residents codes must reflect the care provided during the previous month. A temporary condition may not be claimed. A temporary condition is one that requires a service for less than 50 percent of the month.
- The medical record is the source for information to complete the MMQ. Documentation must be accurate, dated, and signed by the person performing the care. The licensed nursing summary, daily licensed nursing notes, physician's orders and progress notes, ADL flow sheets, medication administration records, treatment records, and care plans should all be reviewed to complete the MMQ. Documentation for assistance with activities of daily living must be associated with resident dysfunction, and the reason given for assistance must relate to this dysfunction as described in the medical plan.
- The following terms should not be used in documentation, since they are not specific: frequently, almost always, often mostly dependent, and almost total assist.
- If a member has been in the facility for less than a month, the score is based on 50 percent of the days the resident has been in the facility.
- Initial MMQs and semiannual MMQs must be signed by a registered nurse. Clinical records must document this activity before the information is forwarded to the nursing facility staff who are responsible for preparing the electronic submission of MMQ data.

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Medicare

- When a member's stay is covered by Medicare, the facility does not need to complete an MMQ.

When Medicare coverage terminates, the member is eligible for conversion to MassHealth. The facility must submit an MMQ (Reason Code 2 for conversion) with an effective date of the first day of MassHealth eligibility. The MMQ is submitted at the end of the month following the issuance of the member's 10-digit recipient identification number.

Completing the Semiannual MMQ

- A semiannual MMQ must be submitted for every MassHealth member who is a resident of the facility on the first day of the reporting period.
- The semiannual MMQ must be completed from documentation for the previous month. It is essential to obtain semiannual MMQ information at the same time each reporting period.

With each semiannual MMQ, indicate the discharge of a resident who is no longer a MassHealth member as of the first day of the current reporting period. For example, if the effective date of the semiannual MMQ period is July 1, 2004, do not enter a discharge that occurred on July 3, 2004.

Item-by-Item Instructions for Completing the MMQ

Submission Reason

Last Name, First, MI: Last name first, first name, then middle initial (if no middle initial, leave MI field blank).

MassHealth ID: Use the 10-digit member identification number.

Code 1 — Admission: The resident is a new MassHealth admission to the facility. Submit the MMQ at the end of the month following the issuance of the member's 10-digit member identification number.

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Code 2 — Conversion: The resident is a new conversion to MassHealth. Submit the MMQ at the end of the month following the issuance of the member's 10-digit recipient identification number.

Code 3 — Category Change: The member's category has changed from the last semiannual assessment. Indicate the changes on an MMQ and submit. Or for a Significant Change, the nursing facility must have submitted an MDS 2.0 for a significant change. Significant changes include improvement and deterioration. Indicate changes on an MMQ and submit the MMQ with an effective date of the first of the month following the event. There must be at least 15 days of documented changes during the previous month to warrant a significant change submission.

Code 4 — Code/Score Change: The scoring or coding for this member changed since the last assessment but the change did not result in a change in category. Indicate changes on the MMQ and submit upon semiannual review.

Code 5: — No codes or scores changed for this member since last assessment. Indicate Reason Code 5 on the MMQ and submit upon semiannual review.

Code D — Discharge: The member has been discharged from the facility.

Admission Date: The date of admission to the facility.

Effective Date: Start date for the category. Enter the month, day, and year for the date that applies as follows:

- a. New MassHealth admission: the date of admission to the facility;
- b. Conversion: the first date of MassHealth eligibility;
- c. Semiannual Update: the first date of the new period; or
- d. Significant Change: the first of the month following the significant change.

Sex: Enter 1 for male, 2 for female.

Race: Enter one of the following codes:

- 1 - White (not of Hispanic origin);
- 2 - American Indian or Alaska Native;
- 3 - Asian or Pacific Islander;
- 4 - Black (not of Hispanic origin); or
- 5 - Hispanic.

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Date of Birth: The member's date of birth.

MassHealth Provider Number: Enter the facility's MassHealth provider number.

Facility Name: Enter the facility's "Doing Business As" name.

Clinical Instructions for the Initial and Semiannual MMQ

To justify the member's casemix score and category, the member's condition and care requirements must be documented for at least 15 days of the month during which the MMQ assessment takes place. If the individual has been a MassHealth member in the facility for less than a month, the score is based on 50 percent of the MassHealth eligible days the member has been in the facility.

In completing the MMQ, information from the physician's orders, monthly nursing summary, nursing progress and daily notes, MDS, care plan, ADL flow sheets, medication record, treatment record, and all pertinent documentation must be reviewed. A licensed nursing summary must be completed **monthly** (or no later than five days after the end of the month), summarizing all of the care provided to the member.

All documentation must be accurate, dated, and signed by the person performing the care. Prompting or predetermining documentation is unacceptable. For example, licensed nurses may not indicate how nurse's aides are to complete an ADL flow sheet by highlighting, circling, or otherwise marking items. Only the original writer who made the original entry may change that entry. Late entries, corrections, and addendums must be made within 15 days of the original entry or before the MMQ is submitted, whichever is sooner. To correct an error, draw a single line through the error, leaving the original entry legible, then initial and date the entry.

The member's score and category are based upon the services provided and recorded through the nurse's and nurse's aide's documentation. When conflicting documentation exists, the lower score will be applied.

Justification for assistance with activities of daily living and special attention must be associated with the member's clinical and functional status as documented by the licensed nurse according to the member's care plan.

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A service may be claimed as either an intermittent PRN service or a continuous service and only as ordered by the physician and documented in the clinical record. For example, oxygen PRN may be claimed under Item 2 ("Skilled Observation Daily"), or continuous or daily oxygen may be claimed under Item 12 ("Skilled Procedure Daily/Other"). Both items must not be claimed on the same MMQ.

To ensure accuracy and objectivity, the monthly nursing summary must be completed by a licensed nurse who provided direct member care or was directly responsible for the care provided. The licensed nurse who completes the monthly nursing summary must not complete the MMQs. The MMQ must be completed by a licensed nurse (RN, LPN) and must be signed by a registered nurse.

1. Dispense Medications and Chart (includes all routine documentation)

Code 1, Score 30 for All Residents

Pouring, delivering, and charting all medications, including psychoactives (see exclusion under Skilled Observation), intermittent I.V. antibiotics, routine injections, PRN medications, eye drops, eye ointments, inhalation aerosols, topical medications, suppositories, miscellaneous brief services such as vital signs that must be taken in conjunction with various medications, routine vital signs, and routine sugar and acetone. All residents receive 30 points since it reflects the necessary presence of a licensed nurse on duty at the nursing unit. The Code and Score data field is prefilled on the data-entry screen.

2. Skilled Observation Daily

No Documented Observations Required — Code 1, Score 0

Daily Skilled Observations — Code 2, Score 15

A skilled observation must be specifically ordered with parameters in writing by a physician, performed by a licensed nurse, and recorded at least DAILY (for example, neurological signs, B/P, and TPR) over and above any vital signs that must be taken and recorded as a prerequisite for the administration of certain medications. This also includes any nonroutine measurement of a resident's condition, such as the need for suctioning a resident with a tracheostomy, observation of the edema and/or congestion in a resident with congestive heart failure, the need for oxygen, and blood tests for insulin administration. This may include the introduction and/or titration of a psychoactive medication for a resident with a diagnosis of a major mental disorder that is defined as one or more of the following:

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- schizophrenia;
- major affective disorder;
- atypical psychosis;
- schizoaffective disorder;
- bipolar depression;
- unipolar depression; or
- organic mental syndrome with associated psychotic and/or agitated behavior;

specifically to:

- titrate the dose for maximum effectiveness;
- manage unexpected harmful behaviors that cannot be managed without a psychoactive medication.

Note: The resident's condition must indicate the clinical complexity and justify the need for skilled observation, with documentation of a current or recent episode within the past 60 days. Document the date and type of episode.

Documentation: Daily licensed nursing documentation must be specific to the observation, including the nursing action and effect. Specific observations must be noted daily on a treatment sheet. Each episode must be documented and dated.

Exclusions:

- routine PRN use or tapering of psychoactive medications;
- aspiration precautions (except in clinically complex situations); and
- monitoring of temperature and signs and symptoms of infection while on antibiotic therapy.

3. Personal Hygiene

Independent — Code 1, Score 0

The resident is independent, assisted only for weekly bath/shower or on a "Restorative Bathing/Grooming" program. Score 0 if both bathing and grooming are Code 1.

Assist — Code 2, Score 18 (See Note below.)

Nursing procedures by staff to maintain personal cleanliness and good grooming including attending and/or assisting with bathing, shaving, and brushing teeth. Attending means continual supervision while the resident performs the personal hygiene task to ensure completion of the task. Includes routine skin care and the use of all bathing products.

Note: Any degree of resident involvement is considered an assist.

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Totally Dependent — Code 3, Score 20 (See Note below.)

Bathing and/or grooming completed entirely by nursing staff without assistance from the resident. "Bath" may take place at bedside, or in a bathing system, shower, or regular tub.

Note: Score is based on the highest level of need in either grooming or bathing.

Example: If the resident is independent in grooming but needs assistance in bathing, the codes are Bathing — 2, Grooming — 1, and the score is 18.

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for bathing or grooming, points may not be scored under "Restorative Bathing or Grooming" program.

4. Dressing

Independent — Code 1, Score 0

This item includes setting out the resident's clothes. Code 1 if the resident is on a "Restorative Dressing" program.

Assist — Code 2, Score 30 (See Note below.)

The resident cannot dress and undress without direct physical, or continual instructional, or continual motivational assistance. This item includes application of all splints (for example, Multipodus or L'nard boots), braces, binders, anti-embolism stockings, and cervical collars. Assistance only with socks and shoes may not be claimed.

Note: Any degree of resident involvement is considered an assist.

Totally Dependent — Code 3, Score 30

The resident cannot dress and undress.

Socks and Shoes Only — Code 4, Score 0

The resident needs assistance with socks, shoes, buttons, bra hooks, or zippers only.

Not Dressed — Code 5, Score 0

The resident wearing night clothes only is "not dressed."

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for dressing, points may not be scored under "Restorative Dressing" program.

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5. Mobility

Mobility describes how the resident walks indoors, once in a standing position, or wheels once in a wheelchair. Transfer (Item 16) describes how the resident gets to the standing or sitting position.

Independent — Code 1, Score 0

The resident is independent if no staff intervention is necessary. This includes the resident who walks with the assistance of equipment (e.g., uses a walker or a cane or wears a wanderguard). Code 1 if the resident is on a "Restorative Ambulation" program.

Independent with wheelchair — Code 2, Score 0

Walks with assist — Code 3, Score 32

The resident can bear own weight but must be physically steadied (one on one) or guided (standby guard) in ambulation by nursing staff, or the resident must be continually monitored, supervised, and given verbal instructions.

Wheelchair with assist — Code 4, Score 32

Wheelchair resident who cannot move or propel alone, or appropriately, because of mental or physical State, or the resident must be continually monitored, supervised, and given verbal instructions.

Nonambulatory/bed bound — Code 5, Score 0

The resident does not move out of his or her bed (nonmobile, bedbound, or bed-to-chair only).

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for mobility/ambulation, points may not be scored under "Restorative Ambulation" program.

6. Eating

Independent — Code 1, Score 0

A resident requiring standard tray preparation (uncover all items on tray, open milk carton) but needs no help eating, is independent. Cutting up meat is considered standard tray preparation. Code 1 if the resident is on "Restorative Feeding" program.

Assist — Code 2, Score 20 (See Note below.)

The resident can bring food to mouth. The resident requires intervention by caregiver, including direct physical assistance, or continual individual or small-group supervision (at a ratio no greater than one staff to eight residents) during the entire mealtime.

Note: Any degree of resident involvement is considered an assist.

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Totally dependent — Code 3, Score 45

The resident is fed by the nursing staff. This item includes syringe feeding when approved in writing by the physician.

Tube fed — Code 4, Score 90

This applies to the resident who is being tube fed only.

I.V. — Code 5, Score 90

This applies to the resident receiving I.V. therapy, or TPN for total nutrition and hydration. I.V. may be scored if required for more than five days of the month.

Tube fed and assist — Code 6, Score 110

In those documented instances where a resident is tube fed and needs assistance with eating.

Tube fed and totally dependent — Code 7, Score 135

In those documented instances where a resident is tube fed and is totally dependent in eating.

Tube fed and I.V. — Code 8, Score 135

This covers the rare instance of a resident receiving both tube feeding and an I.V. (Do not also take points as a "Skilled Procedure," Item 12.)

Note: I.V. therapy refers to nutrition and hydration.

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident and the amount of supervision required.

Note: If points are scored for feeding, points may not be scored under "Restorative Feeding" program.

7. Continence/Catheter

Continent — Code 1, Score 0

The resident is continent or able to request assistance with toileting. Includes the resident who is dependent for transfers but is able to request assistance in advance of need.

Incontinent Occasionally — Code 2, Score 0

"Occasionally" is defined as less than 15 days of the month. Use this code for the residents on bowel and bladder retraining.

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Incontinent and Toileted — Code 3, Score 48

This applies to the resident whose continence is maintained only through regular staff assistance in advance of need. The resident is not able to request assistance but is toileted at least every two hours. Includes incontinent care.

Incontinent — Code 4, Score 48

This applies to regular incontinence due to the resident's inability to control micturition or bowels, or to notify staff of need, and includes incontinent care. (Cannot claim bladder incontinence if the resident is on a bladder-retraining program. Cannot claim bowel incontinence if the resident is on a bowel-retraining program.) This service may be claimed if the resident is regularly incontinent at any time during the 24-hour period or requires routine colostomy, ileostomy, or urostomy care.

Indwelling Catheter — Code 5, Score 20

Prescribed by a physician. Includes insertion, maintenance, catheter care, and cystostomy care and irrigation, if less than daily. (Cannot claim if the resident is on bladder-retraining program, Item 8). Please note that when catheter is irrigated at least daily the service may be claimed as a "Skilled Procedure" in Item 12.

Bowel Incontinent & Bladder Retraining — Score 18

Enter Code 2 for bladder and Code 6 for bowel. Points for Bladder Retraining should be taken in Item 8.

Documentation: The licensed nursing summary must verify ADL status at least monthly. The ADL flow sheet must document daily functional status of the resident.

Score for continence is based on the highest level of need in either Bladder or Bowel.

Example: If Bladder is Code 4, Incontinent, and Bowel is Code 2, Incontinent Occasionally, Score 48.

Exception: If Bladder is Code 5, Indwelling Catheter, and Bowel is Code 3, Incontinent and Toileted, or Code 4, Incontinent, Score 38.

8. Bladder/Bowel Retraining

No Retraining Received — Code 1, Score 0

Bladder Retraining — Code 2, Score 50

A planned and documented program designed to reduce incontinence of urine. Include intermittent catheterization or clamping procedure for bladder retraining here, not to exceed 90 days. Routine toileting to prevent incontinence does not constitute a retraining program. Cannot claim in combination with "Bladder Incontinence," Item 7.

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Bowel Retraining — Code 3, Score 18

A planned and documented program designed to reduce incontinence of feces, not to exceed 90 days. Cannot be claimed in combination with "Bowel Incontinence," Item 7.

Bladder and Bowel Retraining — Code 4, Score 68

Residents on both a bladder and bowel retraining program must meet the requirements listed above.

Documentation: The monthly licensed nursing summary must verify the start date, the goal of the program, the resident's progress or lack thereof, and any revisions to the plan of care. The ADL flow sheet must document the daily functional status of the resident.

Note: The clinical record must contain evidence that the patient has the capacity to comprehend and to participate in a program of bladder and bowel retraining.

9. Positioning

Independent — Code 1, Score 0

Assist — Code 2, Score 36

The resident is essentially helpless to assist himself or herself and must be positioned every two hours while in bed or chair. Adjustment of restraints and routine skin care are provided in conjunction with position change.

Documentation: The monthly must specify the resident's functional status and frequency of positioning and must indicate a reason for the assistance. Daily documentation must specify frequency and position on a positioning sheet or a restraint sheet.

10. Pressure Ulcer Prevention

No Preventive Measures — Code 1, Score 0

Preventive Measures — Code 2, Score 10

Pressure ulcer prevention includes routine diabetic foot care or the use of elbow or heel protectors or handrolls. It may include the use of over-the-counter (nonprescription) creams such as: Desitin, Eucerin, A&D, Vaseline, Aloe Vesta, and Sween Cream, which are used to provide an extra increment of care. There must be documentation of a previous pressure ulcer and/or a current risk assessment using the Braden or Norton scale to indicate moderate or high risk of skin breakdown.

Note 1: Points cannot be taken for the use of an air/water mattress, egg-crate pad, sheepskin, or foot cradles.

Note 2: Incontinent treatment does not necessitate the need for preventive measures, unless the resident has had documented previous skin breakdown.

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Note 3: This item is concerned solely with preventive measures. The following item applies to the treatment of an existing condition.

Documentation: The daily nursing documentation must be specific to indicate the type of care, frequency, and site of application. The monthly licensed nursing summary must specify the reason for preventive measures (previous skin breakdown or current risk assessment). Only the Braden or Norton scale, which must have been completed within the previous 90 days, will be accepted, or the skin breakdown must have been documented within the previous 90 days.

11. Skilled Procedure Daily/Pressure Ulcer

Code the daily frequency of procedure(s) administered (maximum of nine). Enter 0 if no treatments are ordered.

Procedures must be specifically ordered by a physician in writing and must be performed by a licensed nurse. Multiple pressure ulcers at the same or different locations are considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing.

Multiply daily frequency of each procedure by 10 and enter the total score.

Note: In rare situations, different treatments may be ordered for multiple pressure ulcers in different locations. This may be claimed as more than one treatment.

Identify the number of pressure ulcers in each stage (maximum of nine).

Documentation: Daily licensed nursing documentation must be recorded on the treatment sheet. At least weekly, the licensed nurse must record description, size, stage, treatment, and progress of pressure ulcer or ulcers on the treatment sheet.

Clinical stages are described as follows:

Stage 1 Pre-Ulcer: Characterized by unbroken skin surface. An area of induration, erythema, or blue/black discoloration of the skin that does not fade within 30 minutes after pressure has been removed.

Stage 2 Ulcer: Moist, irregular, partial-thickness ulceration limited to the superficial epidermal and dermal layers.

Stage 3 Ulcer: Full thickness extending into the subcutaneous adipose tissue.

Stage 4 Ulcer: Necrotic ulcer extending into muscle, bone, or joint structure.

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12. Skilled Procedure Daily/Other

Skilled procedures are procedures or treatments, other than pressure ulcer treatment, specifically ordered by a physician in writing that must be performed by a licensed nurse. See list of procedures below.

Code the daily frequency of skilled procedures in the single box (maximum of 9). Code 0 if no skilled procedures are needed. If more than one procedure is done daily, add the daily frequency for each procedure and enter the code.

Example: If one procedure is done twice a day and another is done three times a day, the code is 5.

Multiply the sum of the daily frequency of each procedure or treatment by 10 and enter the total on the score line.

Respiratory therapy, continuous or daily oxygen, oxygen therapy, suctioning, and continuous bladder irrigation may be claimed for a maximum of one time per shift. The same treatment to different locations is considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing. Topical medications requiring a prescription may be scored for a maximum of 20 points for a dermatological condition involving epidermal and dermal layers of skin.

Documentation: Daily licensed nursing documentation must specify treatment, frequency, description, and outcome. Specific observations must be recorded daily on a treatment sheet.

Enter appropriate procedure code(s) in the double boxes provided:

- 00 — None
- 01 — Dressing Change
- 02 — Catheter Irrigation
- 03 — Intermittent Catheterization
- 04 — Eye Irrigation
- 05 — Ear Irrigation
- 06 — Care of Heparin Locks
- 07 — Oxygen Therapy (continuous or daily therapy)
- 08 — Tracheostomy Care
- 09 — Sterile Dressing
- 10 — Suctioning
- 11 — Not in use at this time
- 12 — Respiratory Therapy (includes the use of inhalation aerosols for the management of episodes of bronchospasm)
- 13 — New Colostomy Irrigation
- 14 — Other

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13. Special Attention

Coding: A code must be entered for each box A through D. (See Note below for Box C.) Code 0 if not applicable. Code 1 if special attention was required for 15 days of the month reviewed (or 50 percent of the total days if less than a full month).

A. Immobility: Code 1 if the resident is so heavy, helpless, or combative that two or more people are needed to change position, transfer, or ambulate. This includes use of mechanical lifting devices, for example, a Hoyer lift. The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must record the daily functional status.

B. Severe Spasticity or Rigidity: Code 1 if the problem is of such magnitude that it severely limits personal care or ambulation, requiring two or more people. The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must code the daily functional status.

C. Behavioral Problems: Code 1, 2, or 3 may be used for behavioral problems. The disruptive behavior interferes with staff and/or other residents, causing the staff to stop or change what they are doing to control or alleviate the following disruptive behaviors:

- a. Wandering — moves with no rational purpose, appears oblivious to needs or safety.
- b. Verbally Abusive — threatens, screams, or curses.
- c. Physically Abusive — hits, shoves, scratches, or sexually abuses others.
- d. Socially Inappropriate or Disruptive Behavior — performs self-abusive acts, exhibits sexual behavior or disrobes in public, smears or throws food or feces, or rummages through others' belongings.

Note: Code 1 if behavior and intervention have been documented for 15-22 days.

Code 2 if behavior and intervention have been documented for 23-29 days.

Code 3 if behavior and intervention have been documented for 30 or 31 days.

Documentation:

For Code 1, 2, or 3, a current active treatment plan for behavioral problems must be in the medical record.

For Code 1, the licensed nursing summary must verify and summarize the daily documented behavior(s), frequency, intervention(s), and the outcome of intervention(s).

For Code 2 or 3, the daily nursing documentation must specify behavior(s), frequency, intervention(s), and outcome of intervention(s).

For Code 2 or 3, a psychiatric assessment must document the disruptive behavior.

D. Isolation: Code 1 if gowns and gloves are required due to communicable infection or severely impaired immune status.

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14. Restorative Nursing

Restorative nursing refers to care procedures that may require relearning after an illness such as a fractured hip or CVA.

Implementation of specific types of resident reteaching conducted at least five times per week by nursing staff. Intervention and progress must be well documented daily, with time limits and goals clearly stated. This may only be claimed for a period not to exceed 90 days.

May claim points only for the limited time necessary to achieve the stated care plan objective or to prove it impractical, as shown by progress or lack of progress. Time limits for such services as ADL training, ostomy teaching, diabetic teaching, and restorative eating participation are those established during the resident-care planning process (maximum of 90 days).

Code — Enter procedure type(s) in the box(es).

Note: The clinical record must contain evidence that the patient has the capacity to comprehend and to participate in the restorative program.

- 0 — None Required
- 1 — Activities of Daily Living - Dressing
- 2 — Activities of Daily Living - Personal Hygiene
- 3 — Activities of Daily Living - Restorative Eating
- 4 — Ostomy Care/Teaching
- 5 — Diabetic Teaching
- 6 — Ambulation
- 7 — Range of Motion

Score — Enter 30 if any restorative nursing procedures are administered. The maximum score for this item is 30, regardless of the number of programs implemented. Enter 0 if none was provided.

Documentation: The monthly licensed nursing summary must verify time limits, not to exceed 90 days, goals, progress, or lack of progress. The ADL flow sheet must document the daily functional status of the resident.

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(No points are connected with the next 10 items.)

All items must have entries.

15. Toilet Use (use of toileting equipment)

Toilet use refers to how the resident uses the toilet, bedpan, urinal, or commode, including transferring, if necessary, or positioning a bedpan/urinal, cleansing after elimination, and adjusting clothes prior to and after using the toilet. The process involved in getting to the toilet may not be included here.

Code 1 — Independent

Code 2 — Assist

Code 3 — Totally Dependent

Code 4 — Not Toileted (Includes residents who do not use toileting equipment because of incontinence or because they have a catheter.)

16. Transfer

Transfer refers to how the resident gets to the standing position or to sitting in a wheelchair. Mobility (Item 5) is how the resident walks indoors, once in a standing position, or wheels once in a wheelchair.

Code 1 — Independent

Code 2 — Assist

Code 3 — Totally Dependent

Code 4 — Bed bound

17. Mental Status

Inability to remember dates or time, identify familiar locations or people, recall important aspects of recent events, or make straightforward judgments of such recent events, or make straightforward judgments of such a degree that the resident is impaired nearly every day in performance of basic activities of daily living, mobility, and adaptive tasks. Code as follows:

Code 1 — Resident is not disoriented or impaired in memory.

Code 2 — Resident is disoriented or impaired in memory daily.

Code 3 — Mental status is not determined (includes only new admissions and those residents unable to communicate).

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18. Restraint

- Code 1 — The resident does not have a written order for restraints.
- Code 2 — Restraint is ordered but not used on a regular daily basis.
- Code 3 — Restraint is ordered and used daily.

19. Activities Participation

- Code 1 — Always Active
- Code 2 — Occasionally Active
- Code 3 — Rarely Active or Not Active
- Code 8 — Not Yet Determined

20. Consultations

Consultation is defined as a direct visit to a specific resident for reasons other than the required routine visit or admission screening.

Type: Note which type of consultation(s) occurred by entering the appropriate code(s) in the column marked "Type." (If more than three types apply, list the three that are most frequent.) Enter 00 if none and 88 if not determined in the first set of boxes.

- 00 — None
- 01 — Physician
- 02 — Psychiatrist
- 03 — Dentist
- 04 — Podiatrist
- 05 — Physical Therapy
- 06 — Psychologist
- 07 — Dietitian
- 08 — Social Service
- 09 — Occupational Therapy
- 10 — Audiologist
- 11 — Speech Therapy
- 12 — Other
- 88 — Not determined

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Frequency: Note the respective frequency of each consultation by entering the appropriate code(s) in the column marked "Freq.":

- 0 — None
- 1 — Daily
- 2 — 2-3 Times Per Week
- 3 — Weekly
- 4 — 2-3 Times Monthly
- 5 — Monthly
- 6 — One Time Only (PRN)

21. Medications

If selected types of medications have been ordered and administered, indicate the type of medication in the row marked "Medications" using codes below. (Enter first code in the first box.) Enter 0 if none. Medications administered but that are not listed below should not be counted. Under each medication indicate the frequency using the codes below. Only codes listed in the instructions should be used. If more than four medications are administered, enter the ones administered most frequently.

Medications (Prescription Only)

- 0 — None
- 1 — Tranquilizers
- 2 — Sedatives/Hypnotics
- 3 — Antihypertensives
- 4 — Narcotics
- 5 — Pain Relievers (nonnarcotic)
- 6 — AntiPsychotics
- 7 — Antibiotics
- 8 — Antidepressants

Frequency

- 0 — None
- 1 — Regularly
- 2 — PRN
- 3 — One Time Only (includes 10-day order for antibiotics)

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22. Accidents/Contractures/Weight Change

Indicate whether or not the resident has experienced an accident (an accident or incident report was completed) or weight change during the month by entering the appropriate code in each box:

- 1 — Yes
- 2 — No

Note: A weight change is defined as an *unplanned* gain of eight or more pounds or loss of five or more pounds. (A weight change is considered planned when a resident is on a supplement diet, reduction diet, or diuretic program.)

Indicate whether the patient has any contractures by entering the following code in the box marked "C."

- 1 — Yes
- 2 — No

23. Primary Diagnosis

Use ICD-9-CM codes to indicate the diagnosis that is the principle reason for the resident's need for long-term-care services.

24. Secondary Diagnosis(es)

List up to three ICD-9-CM codes for the conditions that have a major relationship to the resident's activities of daily living (ADLs) or cognitive or behavioral status. Leave blank if no secondary diagnoses are present.

Note: ICD-9-CM code books are generally available at major booksellers.

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25. Registered Nurse Signature

The name of the facility's registered nurse completing the MMQ form certifies that the information on the questionnaire is complete, valid and accurate.

26. Date

Enter the date the MMQ is completed.

27. Signature of Administrator

The name of the facility's administrator certifies that the information on the questionnaire is accurate, valid and complete.

28. Affiliation

Enter the appropriate code for the person completing the MMQ:

Code 1 — Nursing Facility Staff

Code 2 — MassHealth

Code 3 — RN contractor